Managing Forms in the Legal Electronic Health Record

by Carol Ann Quinsey, RHIA, CHPS

Forms have always presented challenges for HIM professionals, and managing forms in an EHR implementation remains one of the most challenging and time-consuming tasks of that process. Healthcare organizations transitioning to an electronic record should carefully plan forms to streamline processes and meet the standards required of legally sound business records.

The Forms Approval Process

Forms are developed for many reasons and come from just about every department of the organization. Many forms are necessarily complex because they document and track the details of patient care. Other forms are simple, presenting clinical information in a way that is useful for caregivers, often from disparate sections of a chart.

Most healthcare organizations have established forms committees to review any form that is to be included in the legal health record; however, forms occasionally show up in health records that have not gone through a review process.

It is not uncommon with paper-based health records for unexpected forms to simply appear in unassembled health records in the HIM department following discharge. Such forms may lack required information or lack formatting required to permit later activity with the chart, such as scanning the record into archival media.

Typically forms committees review proposed forms to see if there is a genuine need for the new form. They check whether another form already exists that could meet the user's need. In addition, the proposed form is reviewed for compliance with standards set by the organization to ensure that forms contain required information that allow them to be part of the legal (i.e., business) record of the organization.

Organizations usually require consistent placement of information such as the patient's name, encounter or admission date, the name of the form, and the date of approval. Policies should detail the requirements for margins to ensure legibility in the event forms are bound in some way during or after the episode of care and to accommodate archiving by microfilm or scanning. Organizations may also outline policies on requirements for paper and ink colors.

Taking Forms Digital

When organizations plan the transition from paper to electronic health records, it is imperative that their early activities include planning for the transitioning of forms. Presuming an organization doesn't intend to maintain the paper record as the business record, all forms that will be used in the EHR must meet the standards required for records produced for legal purposes.

To begin the process, organizations should inventory all existing forms. A rigorous forms approval process can provide a starting point for ensuring that all forms in use are evaluated.

If no forms committee exists, one should be established to ensure that every aspect of proposed forms is reviewed, including purpose, content, quality, and compatibility with the technology selected for permanent storage of the record. Another consideration is a form's readiness to be scanned if the organization will be using that technology.

Members on the forms committee should include representatives from clinical, business, and technology departments. Those members with technical expertise will be new to some organizations, but their knowledge is critical to success. Some organizations have found that expanding their current forms committee to include IT staff offers the required technical expertise without the need for a new committee.

Historically, some forms committees were led by staff from the print shop in partnership with the HIM director. Print shop staff were involved to manage the inventory. When moving forms to the digital format, it is important to restructure leadership

of the forms review function since there will be little or no need for managing inventories of paper forms in the future.

Streamlining Data Capture

Electronic forms can reduce the need to capture the same information multiple times. Data captured one time can be used to populate other forms. One step in the form review process should include identification of exactly what field in the EHR will populate each field in a proposed form.

Organizations should determine exactly where the form will reside in the EHR. They should also ask if the form is actually necessary-it may be possible for users to create a customized view of data pulled from different parts of the EHR.

For organizations planning to scan documents, bar-coding can reduce the time required to assemble records. In addition, bar-coding can significantly improve filing accuracy once records are scanned. Often documents are scanned in a random order and grouped together in the permanent record.

Foldout forms in the paper-based health record present special challenges for HIM professionals if the intention is to scan them into the EHR. As with any legal document every page of a document must have appropriate patient identification on it. Since trifold forms often must be separated prior to scanning, every page of a form must include a page number (e.g., 1 of 6, 2 of 6, et cetera) and the date so there is no opportunity for the forms to be scanned or reviewed in the wrong order.

Consents for surgery or other therapies require evaluation as well. Organizations need to ask themselves:

- Will the forms be electronic?
- Will forms that remain in paper be scanned into the EHR after the fact?
- If the forms are electronic, what is the capability for electronic signatures of patients, providers, and witnesses (if required)?
- Can consents be signed before the surgery or therapy in the provider's office, as is often done today?

Technology is available today (most often seen in department stores) that allows capture of signatures without prior authentication. Could this technology be used with the selected EHR system?

In the final analysis, it is entirely reasonable to permit the use of forms found useful by clinical and business staff in an EHR environment. Such forms have always been included in legal health records. With appropriate planning there is no reason that they cannot continue to be used to display information in ways that are beneficial.

Resources

AHIMA e-HIM Work Group. "Electronic Document Management as a Component of the Electronic Health Record. Appendix B: Specific Forms Characteristics." October 2003. Available online in the FORE Library: HIM Body of Knowledge at www.ahima.org.

Westhafer, Kathy J. "The Forms Management Process: Keeping Pace with EHR Development." *Journal of AHIMA* 76, no. 8 (September 2005): 66–67.

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